OptumRx has partnered with CoverMyMeds to receive prior authorization requests, saving you time and often delivering real-time determinations.
Visit go.covermymeds.com/OptumRx to begin using this free service.
Please note: All information below is required to process this request.
Mon-Fri: 5am to 10pm Pacific / Sat: 6am to 3pm Pacific

Luxturna™ Prior Authorization Request Form

DO NOT COPY FOR FUTURE USE. FORMS ARE UPDATED FREQUENTLY AND MAY BE BARCODED

Member Information (required)			Provider Information (required)		
Member Name:			Provider Name:		
Insurance ID#:			NPI#:	Specialty:	
Date of Birth:			Office Phone:		
Street Address:			Office Fax:		
City:	State:	Zip:	Office Street Address:		
Phone:			City:	State:	Zip:

Medication Information (required)

Medication Name:	Strength:	Dosage Form:
❑ Check if requesting **brand**	Directions for Use:	
❑ Check if request is for **continuation of therapy**		

Clinical Information (required)

Select the diagnosis below:

❑ RPE65 mutation-associated retinal dystrophy

❑ Other diagnosis: ____________________________________ ICD-10 Code(s): ________________________________

Clinical Information:

Does the patient have a diagnosis of confirmed biallelic RPE65 mutation-associated retinal dystrophy (e.g., Leber's congenital amaurosis [LCA], retinitis pigmentosa [RP], early onset severe retinal dystrophy [EOSRD], etc.)? ❑ **Yes** ❑ **No**

Select if Luxturna is used for the treatment of vision loss defined by the following:

❑ Visual acuity worse than 20/60 in both eyes

❑ Visual field less than 20 degrees in any meridian as measured by III4e isopter or equivalent in both eyes

Does the patient have sufficient viable retinal cells as determined by optical coherence tomography (OCT) demonstrating an area of retina within the posterior pole of greater than 100 micron thickness? ❑ **Yes** ❑ **No**

Select if Luxturna is prescribed by or in consultation with one of the following physicians associated with an ocular gene therapy treatment Center of Excellence:

❑ Ophthalmologist

❑ Retinal specialist/surgeon

Will Luxturna be administered by a retinal specialist/surgeon experienced in performing intraocular surgery? ❑ **Yes** ❑ **No**

Has the patient previously received RPE65 gene therapy in the intended eye? ❑ **Yes** ❑ **No**

Are there any other comments, diagnoses, symptoms, medications tried or failed, and/or any other information the physician feels is important to this review?

____

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Please note: This request may be denied unless all required information is received.
For urgent or expedited requests please call 1-800-711-4555.
This form may be used for non-urgent requests and faxed to 1-800-527-0531.

This document and others if attached contain information that is privileged, confidential and/or may contain protected health information (PHI). The Provider named above is required to safeguard PHI by applicable law. The information in this document is for the sole use of OptumRx. Proper consent to disclose PHI between these parties has been obtained. If you received this document by mistake, please know that sharing, copying, distributing or using information in this document is against the law. **If you are not the intended recipient, please notify the sender immediately.**

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